National Alliance on Mental Illness

December 7, 2018

Commission's Secretary
Office of the Secretary
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: WC Docket 18-336 and CC Docket 92-105
Implementation of the National Suicide Hotline Improvement Act of 2018

Dear Secretary Dortch:

NAMI, the National Alliance on Mental Illness, appreciates the opportunity to submit comments on the implementation of the National Suicide Hotline Improvement Act of 2018. NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

NAMI's members are directly affected by both mental health crises and suicide. About one in eight visits to emergency departments involve mental health and substance use conditions.[i] Tragically, 46% of those who die by suicide have a known mental health condition,[ii] a fact made all the more alarming by suicide rates that continue to climb. Emergency departments visits for non-lethal self-harm have also increased—by more than 40% from 2001-2016.[iii] Combined, self-harm and suicides alone cost our country an estimated $70 billion per year in direct medical and work loss costs.[iv]

Our nation is experiencing a mental health and suicide crisis; it deserves a crisis n11 response.

We urge the Commission to designate a 3-digit number, such as 611, that will make it easy for all Americans to know who to call in a mental health crisis.

Today, people experiencing mental health crises and suicidal thoughts are faced with a plethora of hard-to-remember hotline numbers that often lack the infrastructure, staff and supports to provide the right response at the right time. A national 3-digit number will be an important first step in getting people the help they need and deserve.

It is also important to note that our understanding of mental health crises has evolved—and our crisis response should, too. We urge the Commission to make recommendations that reflect both what we know works and acknowledges the need for an infrastructure that can respond to new technologies and research related to mental health crises and suicide prevention. Specifically, we encourage the Commission to consider recommending the following concepts:

1. **A robust response:** A national mental health and suicide hotline should be able to effectively and compassionately respond to and de-escalate people in crisis and, importantly, should have access to real-time information about and ability to schedule outpatient and intensive specialty mental health services, psychiatric inpatient and crisis stabilization/respite services, the ability to dispatch 24/7 mobile crisis teams, and the capacity to provide follow-up communications to ensure people have "safe landings." These components are showing demonstrable success where implemented and are highlighted in CMS' new guidance to State Medicaid Directors.
2. **Graduated expertise:** A national mental health and suicide hotline should be able to effectively answer its callers. The national Poison Control Center model uses trained responders with

increasingly specialized expertise to provide a graduated response. Having well-trained mental health responders and access to responders with increasingly specialized expertise for more complex, acute or specialized needs (such as LGBTQ) should be explored as a way to better serve people in crisis.

3. **Text, voice, chat:** A national mental health and suicide hotline should mirror how people communicate and their changing preferences, which include text and chat. In addition, a hotline should be dynamic and flexible to incorporate new technologies emerging from research on the power of voice and/or text patterns to assess emotional distress and identify people at high risk.
4. **Confidential, not anonymous:** A national mental health and suicide hotline should protect confidentiality, but not provide anonymity. Anonymity reduces the ability to improve services and prevents people from getting important care, such as the follow-up that research shows is critical to reducing suicides and getting people connected to services.
5. **Location tracking:** A national mental health and suicide hotline should be able to get location information using cell towers or other technology to best determine what services are available to a caller and how to reach a caller in need.
6. **Rollover capability:** A national mental health and suicide hotline should be available to answer every call, even if a local call center is unable to handle volume or is affected by a local disaster. To do so, a hotline needs the capability of rolling over to a nearby or national call center.
7. **Quality improvement:** A national mental health and suicide hotline should have a strong training and quality assurance and improvement program that allows for growth in capacity and expertise, particularly for underserved populations, including youth and older adults, who are at high risk of suicide.

NAMI encourages the Commission to consider the need for a public education campaign to complement an improved infrastructure, operations, and resourcing of a national three-digit hotline for mental health crises and suicide prevention. We also believe that there is value of considering a federal working group that would bring together key stakeholders, including people with mental illness and families, to help champion a vision of better care for the millions of Americans that experience psychiatric crises.

As an organization that is dedicated to improving the lives of people with mental health conditions, we want to thank the Commission for their attention and commitment to the issue of a dedicated three-digit access number and the role of a national crisis response system for mental health crises and suicide prevention.

Sincerely,

Mary Giliberti, J.D.
Chief Executive Officer

---

[i] Weiss AJ (Truven Health Analytics), Barrett ML (M.L. Barrett, Inc.), Heslin KC (AHRQ), Stocks C (AHRQ). Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006–2013. HCUP Statistical Brief #216. Agency for Healthcare Research and Quality, Dec 2016, http://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf

[ii] Morbidity and Mortality Weekly Report, "*Vital Signs:* Trends in State Suicide Rates—Unites States 1999-2016 and Circumstances Contributing to Suicide—27 States, 2015". Centers for Disease Control and Prevention. June 2018, https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm?s_cid=mm6722a1_w

[iii] *Ibid.*

[iv] CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: US Department of Health and Human Services, CDC, National Center for Injury Prevention and Control; 2018. https://www.cdc.gov/injury/wisqars/index.html